Community Based Support South Inc

July 2010

Submission

Productivity Commission Inquiry

Caring for Older Australians

Community Based Support South Inc recognises the wide range of other submissions to this Inquiry and has chosen to limit its submission to two issues which significantly impact upon service provision in our own and similar areas, namely:

- The availability of staff and costs of aged care in rural and remote localities
- The shortage of allied health professionals (especially occupational therapists) in Tasmania

CBS South Submission

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About CBS

Community Based Support South Inc was incorporated in 1988 and provides a wide range of community care services to approximately 4,000 frail older people and people with disabilities each year (as well as respite services to their carers) throughout the southern region of Tasmania (the 0362 telephone region). This region has substantial rural and remote areas. CBS currently has 12.07% of its HACC consumers in rural and remote areas (although not all of these would be affected by the examples shown later in this submission).

Our expertise is both in the effective operation of consumer driven 'in-home' services by our 160 field staff and contractors, as well as in providing information and respite services through the Southern Tasmanian Commonwealth Respite and Carelink Centre. All field staff are nationally accredited in Aged and/or Disability Support to Level III or above. There are 40 office based staff.

The nine Directors (all elected by consumers) are drawn from the consumer base and interested professionals.

CBS fosters a thoughtful approach to community care, with the majority of office staff having a related diploma or undergraduate degree or higher. CBS has a thriving consultative process to engender considered approaches to planning and renewal.

Our Concerns and Approach

In the short term, CBS is concerned that a unit cost based approach to service provision would tend to disadvantage both consumers and providers of community care services in rural and remote areas. CBS will show that costs in rural and remote areas can vary unpredictably both as a result of staff shortages in those areas and due to the application of the current IR laws. We have no dispute with these laws, since they were put in place to ensure the reasonable remuneration of staff (which assists in staff retention). However, travel times, vehicles cost reimbursements and minimum shift hours increase costs dramatically in rural and remote areas compared with city and town based clients.

In the medium to longer term, CBS is concerned to ensure the implications of the Intergenerational Report are considered and planned for within our region and more broadly. We would like to be assured that all of the relevant regional implications are fully considered in broad-scale planning.

Should there be opportunity, CBS would also appreciate dialogue with the Commission on the above and any other matters raised by the Inquiry, by whatever means the Commission sees fit.

Costs of Aged Care in Rural and Remote Localities

The two main difficulties we have found in rural and remote areas are finding suitable staff and providing services at a reasonable cost that we are in a position to control and/or predict.

Availability of suitable staff

The problem of staff availability is fairly widely recognised (for instance, as reported in The Tasmanian Social Inclusion Strategy Report, Tasmanian Department of Premier and Cabinet, 2009). Younger, active and trained people often leave rural and remote areas, especially established farming areas, to find work in towns and cities, leaving isolated older people on properties which may now also be less productive.

Those older people tend to wish to stay but become increasingly immobile and are thus less able to travel for services or, due to reduced incomes, are unable to buy them in. With few qualified (or even unqualified) staff living in these areas, services such as ours face multiple difficulties.

For consumers in rural and remote locations, several questions apply: Do service providers (including CBS) have staff in the area? Is anyone prepared to travel to provide service? If there is someone available, what will it cost?

The variable cost of service

In the recent past (under AWAs), costs were similar in all areas (assuming staff were available). At the same time, the AWAs, unfortunately, tended to remunerate staff inadequately. However, Awards and EBAs, under the current rules, tend to increase costs as indicated in the following examples.

Scenario 1

Mrs J, aged 82, lives at D Crescent, Firestone

Worker A attends for one hour each on Monday, Wednesday and Friday. Under the Award, the minimum period of engagement would be two hours for each occasion. Thus the wages cost of three weekday services would be six hours of pay.

However, if even just one of the services were being regularly supplied on a weekend or evening, Worker A would have to be classified as a Shift Worker. Under the Award, Shift Workers have a minimum period of engagement of four hours (plus any penalty rates). In this case, the cost for each of the one hour services on the weekdays would be four hours of pay and on the Saturday, Sunday or Public Holiday, the rate would be four hours at penalty rates. Penalty rates can be up to 2.5 times normal rates. The maximum cost could then be as much as 18 hours of pay for 3 hours of service, although the average would be closer to 15 hours for three hours of service.

Under the above scenario, the cost could therefore vary between 6 to 15 hours of pay for three hours of service (and the circumstances might well be outside the control of the provider - ie the variation may be somewhat unpredictable unless the provider can avoid weekend services).

Could there be other responses?

What if a worker were brought in from elsewhere (including from another provider)? As it turns out, there is no other staff member of CBS within 50Km and no other staff from another provider within 30Km. In the first case, no staff member is prepared to travel 50km each way without an incentive payment plus distance covered reimbursed at the Km travelled rate, plus travel time, and the other provider wants a substantial premium to provide service at this distance. In each case the cost is within the range already covered above.

Other responses could also be envisaged.

The provider might consider either directly or indirectly interfering in the allocation process to increase the daily allocations and thus reduce the apparent unit cost of service (as would occur if the daily allocation were not one hour but anything up to four).

This approach would not be equitable or honest and could in any case be thwarted to some extent by funders by various means but the result could be that the provider refused to provide the service. This would leave the client without support. An alternative, currently utilised by DVA, is to have contractual arrangements that bind the provider to supply service. The problem for providers with substantial exposure to rural and remote clients is that the provider's costs become too great a burden, potentially resulting in insolvency.

In such a case, the likelihood of another provider being available would be further reduced. What then happens to the client, worker and the other staff and clients of the provider (and others in rural and remote areas)?

Is there potential to reduce costs under an appropriate Enterprise Bargaining Agreement?

The answer to this must remain equivocal. EBAs can provide greater flexibility but the worker would usually still need to sign an Individual Flexibility

Agreement (IFA); the possibility remains that such an IFA could be revoked solely by that worker with a month's notice.

Under block funding models, with appropriate audits, guidelines and quality controls, the provider, if shown to be efficient, can continue to provide service without facing insolvency.

Under almost any unit cost model, the cost variability, as indicated above, is too unpredictable as each rural and remote area could be substantially different from others both at present and at any future time (depending on numbers of clients/services/service durations and staff as well as temporal and physical separations).

The logical question the Inquiry might ask then is: 'Why does the DVA unit cost model appear to work?'

Our answer would be to point out that the DVA approach only works to a point. At present, most if not nearly all DVA providers with substantial exposure in rural areas, also have multiple other funding sources from which cross-subsidisation occurs more or less openly.

Were the DVA approach generalised, with unit cost contracts tying providers into providing services at prices below average costs in remote and rural areas, some providers would suffer unreasonable financial disadvantage.

Scenario 2

Four clients/consumers/recipients, each at HACC low care and receiving 3 hours per week of service, within a moderate distance of each other in a remote location.

Mrs J, aged 82, lives at D Crescent, Firestone

Mr S, aged 85, lives at A Road, Arthurs Lake, 8Km (7 minutes) from Mrs J

Ms W, aged 79, lives at P Road, Arthurs Lake, 10Km (8 minutes) from Mr S

Mrs N, aged 91, lives at J Road, Arthurs Lake, 15Km (11 minutes) from Ms W

All four clients receive weekday service from Worker A and all services are provided back to back with only travel time between. In this case the cost is only marginally more than in larger towns and cities at about hourly rate plus around 25% for travel reimbursement and travel time.

Of course, this quickly breaks down as soon as service times cannot be worked back to back (back to back all of the time is unusual), or if one of the clients wants a different worker (perhaps a gender related or other factor that must be responded to).

In Case 2, costs could vary anywhere between being just over the unit cost in a larger town or city to the highest cost applying in Case 1. The main issue for the service provider would be that they would have little control over these costs.

Separate related issue - Community Packaged Care

In addition to the above costs of providing support to rural clients, there is the additional cost of client transport for Community Packaged Care recipients in rural and remote areas. CBS currently delivers CACPs in rural areas. Community Packaged Care is inadequately compensated in instances such as the following scenario:

Case Scenario

A client lives at South Arm, 38 kms from Hobart. Providing assistance to appointments involves a one way journey of 35 – 50 minutes, depending on traffic conditions.

Where the client requires transport to hospital appointments in Hobart, options are:

1. Provide a worker to transport the client. The cost of this option includes $54.72 for the distance travelled by the worker and approx 3 hrs support time (i.e. up to 1 hour travel each way and at least 1 hour for the actual appointment time, if the doctor is on time – something our clients rarely experience). Although this client lives relatively close to the city, the labour cost alone is at least double that for a city based client (and to that must be added the higher travel reimbursement of $54.72)

   This is often the most suitable option where the client requires a worker to assist at the appointment, with transfers, dressing undressing, toileting assistance etc.

2. Provide taxi vouchers. This option costs around $150.00 for the same visit as above but has the advantage of not committing a worker to a block of time - when the client only requires transport and does not need support at the actual appointment.

3. Try to connect with community transport. Again this option is dependent on the client not requiring someone to be with them at the appointment. Some areas, including South Arm only have one community transport vehicle which may not be available when required.

Shortage of Allied Health Professionals (Especially Occupational Therapists) in Tasmania

CBS does not employ Occupational Therapists but delivers services that in part rely on inputs from OTs. There is, however, considerable scope for further involvement of OTs and other allied health professionals for assisting to keep older Australians more well, thus reducing their need for regular 'one on one' services.

We understand that a report was prepared by the Independent Living Centre (based in Launceston, Tasmania) that shows that despite Tasmania now having the highest proportion of older Australians, and therefore the greatest need for Occupational Therapists, it also has about half the national proportion of Occupational Therapists per head of population.

If the wellness of older Australians is of concern, then this shortage needs to be addressed. [There may be a similar situation in respect of other allied health professionals but CBS has neither undertaken the analysis nor is it in a reasonable position to do so.]

Our related concern regarding the shortage of (at least certain) allied health professionals, is that the Intergenerational Report indicates that we will not have the overall number of staff in future to continue to provide one on one services in the quantity per person we have in the past. Therefore allied health professionals will be in the front line of assisting older Australians to keep well, fit and independent of regular service use, so that we can (we hope) keep up with demand. Unless we start additional training now, we will be too late to meet foreseeable needs.

We also draw the Inquiry's attention to the particular problems of regional areas in relation to the retention of allied health professionals. The Royal Hobart Hospital is a teaching hospital, and is therefore able to attract new graduates in limited numbers from elsewhere. The flip side of this is that, being from elsewhere, these graduates tend to return to their place of origin after completing a short period here. This is exemplified by our own regular visits to the Occupational Therapy Unit at the RHH. The staff turnover rate is notable, and when asked where previous staff had gone, the answer is almost invariably "back to Melbourne, Sydney, Brisbane, etc".

Given the propensity of people to return to the place of their growing up years, we believe there would be merit in exploring means to either teach these vocations locally or to enhance the access of Tasmanians and other regional Australians to existing teaching locations. The second option is less preferred as a proportion will not return, whereas locally trained people are more likely to stay.

Another alternative might be to provide financial incentives of sufficient value to attract these professionals to work in rural and remote areas.

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